

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE 15-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL						d. STREET ADDRESS 263 CONGRESSIONAL LANE					
3. NAME OF DECEASED (Type or print) First NIHIL Middle ESTEBAN Last RAMIREZ						4. DATE OF DEATH Month JUNE Day 29 Year 1966					
5. SEX MALE		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-29-66		9. AGE (In years last birthday) yrs. 2 Months 0 Days 0 Hours 0 Min. 0		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE MANAGER				10b. KIND OF BUSINESS OR INDUSTRY GOODYEAR TIRE + RUBBER				11. BIRTHPLACE (County & State, or foreign country) HAVANA, CUBA		12. CITIZEN OF WHAT COUNTRY? CUBA	
13. FATHER'S NAME NIHIL ESTEBAN RAMIREZ						14. MOTHER'S MAIDEN NAME KIRIE OTA					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NO		17. INFORMANT MOTHER		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 774 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anoxia DUE TO (c) Immaturity										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6-29-1966 , to 6-29-1966 , that (I) (we) last saw the deceased alive on 6-29-1966 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE [Signature]						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) George Ellis, Sr.						22d. ADDRESS 50 W. Edmondston Drive, Rockville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/2/66		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City, town or county) (State) Silver Spring Montg. Md.			
24. FUNERAL DIRECTOR Tyson Wheeler ADDRESS 1331 Rockville Pike Rockville, Maryland						25a. REC'D BY REGISTRAR JUL 8 1966 25b. REGISTRAR'S SIGNATURE [Signature]					

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G578 7/6/66 mh

08718

CERTIFICATE OF DEATH

08708

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>12201 Village Green</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edward Joseph Reardon</u> First Middle Last 4. DATE OF DEATH <u>June 23 1966</u> Month Day Year				5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIAGE STATUS <u>WIDOWED</u> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
8. DATE OF BIRTH <u>8-17-01</u> 9. AGE (In years last birthday) <u>64</u> yrs. IF UNDER 1 Year Months Days IF UNDER 24 HRS. Hours Min.				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Correspondent</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>News</u> 11. BIRTHPLACE (County & State, or foreign country) <u>New York City, NY</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Mark Reardon</u> 14. MOTHER'S MAIDEN NAME <u>Naughton</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>149-10-2303</u> 17. INFORMANT <u>Daughter</u> Address <u>Springfield, Ill. Mrs. Maureen Taylor - 7410 Gary St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUBARACHNOID HEMORRHAGE, (R) MIDDLE CEREBRAL</u> 330 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>2 YEARS</u> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS AND (L) CAROTID THROMBOSIS</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>January, 1966</u> , to <u>June 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 22 1966</u> , and that death occurred at <u>145AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Frederick S. Caldwell</u> 22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S. CALDWELL</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>50 W. EDMONDSTON DR ROCKVILLE, MD</u>		22b. DATE SIGNED <u>23 June 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>6-27-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Fairfax Va</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> 5130 Wisc. Ave. N.W. Wash. D.C.				25a. REC'D BY REGISTRAR <u>JUN 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>University Park, Md - 16-2</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		d. STREET ADDRESS <u>4425 Underwood St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fannie Mason Rector</u>		4. DATE OF DEATH Month Day Year <u>June 23 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/26/24</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James A. Goodwin</u>		14. MOTHER'S MAIDEN NAME <u>Emily F. Mason</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bacterial infection</u> DUE TO (c) <u>Hypostatic pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u> <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/13</u> , 19 <u>63</u> , to <u>6/23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/22</u> , 19 <u>63</u> , and that death occurred at <u>322</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Kenneth Cruze</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>6/23/66</u>
22c. PHYSICIAN'S NAME (Type) <u>Kenneth Cruze, M.D.</u>		22d. ADDRESS <u>7600 Carroll Ave Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-27-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>JUN 27 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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RECORD OF

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u> c. LENGTH OF STAY IN lb. <u>319 Wash Blvd</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Manor Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> d. STREET ADDRESS <u>319 Wash Blvd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Edith Ellen Redmiles</u>				4. DATE OF DEATH Month <u>6</u> Day <u>25</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 25 1879</u>			
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>William Leishure</u>					
14. MOTHER'S MAIDEN NAME <u>Mary Ann Turner</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					
16. SOCIAL SECURITY NO. <u>no</u>				17. INFORMANT <u>Mrs George Smith, Laurel, Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary atherosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 hr</u> <u>Indef</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6/24/66</u> to <u>6/25/66</u> and that death occurred at <u>11:45 AM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Stephen N. Jones</u>				22b. DATE SIGNED <u>6/25/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN N. JONES</u>				22d. ADDRESS <u>Rockville Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-28-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loy Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Laurel Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Donaldson</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>					

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From Ellen G. White

My dear friends,
I am writing you
a few lines to let
you know that I am
still alive and well.

Yours truly,
Ellen G. White

Ms. A. 9. 2. 22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Anne Arundel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fulton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>						d. STREET ADDRESS <u>Pindell School Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>E.</u> Last <u>Remmer</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1966</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/20/1885</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Albert H. Remmer</u>				Address <u>Same as #2 (son)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLI, MULTIPLE</u> 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROSIS, GENERAL</u> DUE TO (c) <u>PERNICIOUS ANEMIA, UNTREATED</u>										INTERVAL BETWEEN ONSET AND DEATH <u>UNK.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PERNICIOUS ANEMIA, UNTREATED</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>24 MAY</u> , 19 <u>66</u> , to <u>2 JUNE</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>31 MAY</u> , 19 <u>66</u> , and that death occurred at <u>1:35</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>J. Richard Compton</u>						22b. DATE SIGNED <u>2 June 66</u>		22c. PHYSICIAN'S NAME (Type) <u>J. RICHARD COMPTON MD</u>		22d. ADDRESS <u>612 MAIN ST. LAUREL, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/4/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor P.G. Md.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>						ADDRESS <u>Hyattsville, Md.</u>		DATE <u>JUN 6 1966</u>			

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4252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or other disposal, and in any event, within 72 hours after death.

1 (M)

CERTIFICATE OF DEATH

08722

08712

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN Tb <u>154</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>		d. STREET ADDRESS <u>6015 Dellwood Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Elise</u> Middle <u>Browning</u> Last <u>Richardson</u>		4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-26-90</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Pu. Co - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Clay Browning</u>		14. MOTHER'S MAIDEN NAME <u>Blanchette Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-54-1369</u>	
17. INFORMANT <u>Gail Richardson</u>		Address <u>Home</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Asphyxiation</u> DUE TO (c) <u>Asphyxiation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-27-66</u> , 19 <u>66</u> , to <u>6-8-66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-8-66</u> , 19 <u>66</u> , and that death occurred at <u>440</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Alan J. Chenery</u>		22b. DATE SIGNED <u>6-13-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Alan J. Chenery</u>		22d. ADDRESS <u>915 19th St. N.W. Wash., D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>6-9-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 13 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATE



CERTIFICATE OF DEATH

08713

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 5 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS RFD 1	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Magruder Last Riggs		4. DATE OF DEATH Month June Day 28 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-87 1877
9. AGE (In years last birthday) 89 yrs		IF UNDER 1 YEAR Months 89 Days 89	IF UNDER 24 HRS. Hours 89 Min. 89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edwards, Waters		14. MOTHER'S MAIDEN NAME Columbia Magruder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hosp. Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Cardio-vascular-renal Disease with hypertension. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 day 30 years 30 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) McKendree Boyer, M.D. attended the deceased from 1935 , 19__ to 6/28/66 , 19__, that (I) see lost saw the deceased alive on 6/28/66 , 19__, and that death occurred at 5 a. M, from causes and on the date stated above.			
22a. SIGNATURE McKendree Boyer, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. M.M. Boyer		22d. ADDRESS 9701 Church Street, Damascus, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 30 1966	23c. NAME OF CEMETERY OR CREMATORY Goshen	23d. LOCATION (City or Town) (County) (State) Laytonsville Mont. Md
24. FUNERAL DIRECTOR Francis H. Barber		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Laytonsville Md		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

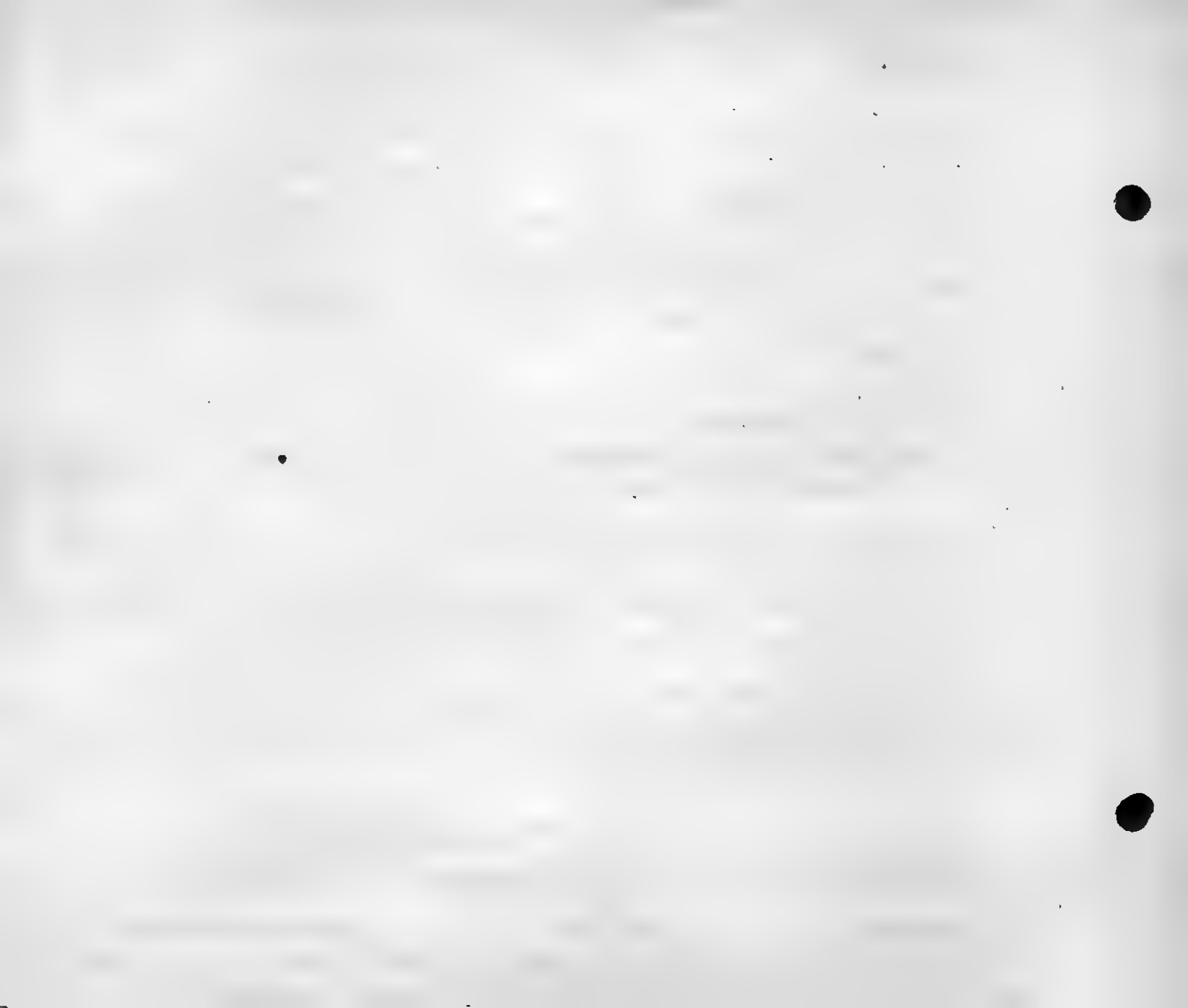
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00724

08714

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Norbeck</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Norbeck</u>			
c. LENGTH OF STAY IN 1b <u>years.</u>				d. STREET ADDRESS <u>4516 Muncester Mill Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4516 Muncester Mill Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ellen</u> Middle <u>Robinson</u> Last <u>Riley</u>				4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3, 1880</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>—</u>							
13. FATHER'S NAME <u>Phil. C. Riley</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Helen M. Sproesser</u>				Address <u>12826 Holdridge Rd Wheaton Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Bronchial</u>							
DUE TO <u>Malnutrition</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John G. Ball</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/10/66</u>			
				Address (Street, city, town, or county) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/14/66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR <u>W. W. Chambers, Inc.</u> ADDRESS <u>8655 Georgia Ave Silver Spring, Md</u>				24a. REC'D BY REGISTRAR <u>JUN 14 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



00725

CERTIFICATE OF DEATH

00715

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY IN 1b 1 yr		d. STREET ADDRESS 22 Randolph Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home 22 RANDOLPH RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isabelle Middle Stella Last Robey		4. DATE OF DEATH Month June Day 14 Year 1966	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-90
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75	IF UNDER 24 HRS. Hours 75 Min. 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Amos Burriss		14. MOTHER'S MAIDEN NAME Sarah Burriss GATES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH (Enter only one cause pertaining for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) Constrictive Heart Failure Hypertensive Cardiovascular Disease Nephropathy, Chronic		INTERVAL BETWEEN ONSET AND DEATH 1 mo. Yrs Yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 18	20f. (City or town) (County) (State) 614 4
21. I certify that (I) (this hospital) attended the deceased from 1966 , to 6/14 , 19 66 , that (I) (we) lost saw the deceased alive on 6/14 , 19 66 , and that death occurred at 6A M, from causes and on the date stated above.			
22a. SIGNATURE Charles H. Ligon, M. D.		22b. DATE SIGNED 6/14/66	
22c. PHYSICIAN'S NAME (Type) Charles H. Ligon, M. D.		22d. ADDRESS Sandy Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6-16-1966	23c. NAME OF CEMETERY OR CREMATORY COLESVILLE, METHODIST	23d. LOCATION (City or Town) (County) (State) COLESVILLE, MARYLAND
24. FUNERAL DIRECTOR W. W. Chambers & Co. Riverdale, Md.		25a. REC'D BY REGISTRAR JUN 16 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health for removal, and in an event, within 72 hours after death.

00726

CERTIFICATE OF DEATH

00716

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington b. COUNTY King	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN TB 49 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 2605 109 Place N.E.	
3. NAME OF DECEASED (Type or print) Candace Jean Roetman		4. DATE OF DEATH Month June Day 25 Year 1966	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 October 1949
9. AGE (In years last birthday) yrs 16		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Minneapolis, Minn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Orvil Roetman		14. MOTHER'S MAIDEN NAME Lavera Jones D.C.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mr. Orvil Roetman		Bellevue, Washington, 2605 109 Place N.E.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2043 IMMEDIATE CAUSE (a) Acute Leukemia DUE TO (b) - DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 7, 1966 to June 25, 1966 , that (I) (we) last saw the deceased alive on June 25, 1966 , and that death occurred at 10:46 P.M. from causes and on the date stated above.			
22a. SIGNATURE J. E. Zimmerman		22b. DATE SIGNED June 26, 1966	
22c. PHYSICIAN'S NAME (Type) J. E. Zimmerman		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 6-28-1966	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City or Town) (County) (State) Portland, Oregon
24. FUNERAL DIRECTOR Joseph Gawler & Sons		25a. REC'D BY REGISTRAR 5130 Wisconsin Ave. N.W.	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		DATE JUN 30 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08727

08717

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		c. LENGTH OF STAY IN 1b <u>35 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> 3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Son. Hosp.</u>		d. STREET ADDRESS <u>2903 Grae Loch Rd.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>FERDINAND</u> Last <u>ROSE</u>		4 DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer for Govt U.S. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	9. AGE (In years last birthday) <u>87</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>George X Rose</u>		14. MOTHER'S MAIDEN NAME <u>Emily Delano</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Mrs. Lillian Rose</u> Address <u>2903 Grae Loch Rd. Laurel, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Failure</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Infarction</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/13/66</u> , 19 <u>66</u> , to <u>6/16/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/13/66</u> , 19 <u>66</u> , and that death occurred at <u>8:55 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Smith, Jr.</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/16/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Smith, Jr.</u>		22d. ADDRESS <u>Burtonsville, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>18 June 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Wanner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. RECD BY REGISTRAR <u>JUN 20 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>2 1/2 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			d. STREET ADDRESS <u>6124 Durbin Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Blume</u> Middle <u>Rosenblum</u> Last <u>Rosenblum</u>			4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1966</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 2, 1888</u>		9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SHEA UHLMAN</u>					14. MOTHER'S MAIDEN NAME <u>BRINA GREEN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>SON-IN-LAW</u> Address <u>6124 DURBIN RD. BETH. MD.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>?</u> <u>6 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>June 12, 1966</u> to <u>June 13, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 12, 1966</u> , and that death occurred at <u>12 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>George Sharpe M.D.</u>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <u>GEORGE SHARPE MD</u>					22d. ADDRESS <u>10511 SUMMIT AVE. KENSINGTON MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-14-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN FALLS CHURCH VA</u>			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR <u>Bernard Danzansky and Sons 3501-14th St.</u>					25a. REC'D BY REGISTRAR <u>JUN 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
08719											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>						d. STREET ADDRESS <u>10109 Portland Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Hunter Ross, Jr.</u>			First Middle Last			4. DATE OF DEATH <u>June 7 1966</u>			Month Day Year		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 15, 1899</u>		9. AGE (In years last birthday) <u>66 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Good Broker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale Foods</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Joseph H. Ross, Sr.</u>						14. MOTHER'S MAIDEN NAME <u>Violet Parsons</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-03-1122</u>		17. INFORMANT <u>Marie C. Ross</u>		Address <u>10109 Portland Road Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metabolic Acidosis</u> <u>44</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Respiratory failure</u> DUE TO (c) <u>Hypertensive Arteriosclerotic heart disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Liver Cirrhosis of Liver; Carcinoma of Liver</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>4 June, 1966</u> to <u>7 June, 1966</u> that (I) (we) last saw the deceased alive on <u>7 June, 1966</u> , and that death occurred at <u>6:55 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Thomas P. Fogarty</u>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7 June 66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Thomas P. Fogarty</u>						22d. ADDRESS <u>1011 University Blvd., E., S.S., Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>June 10, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Prince Georges, Co., Md.</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>						ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



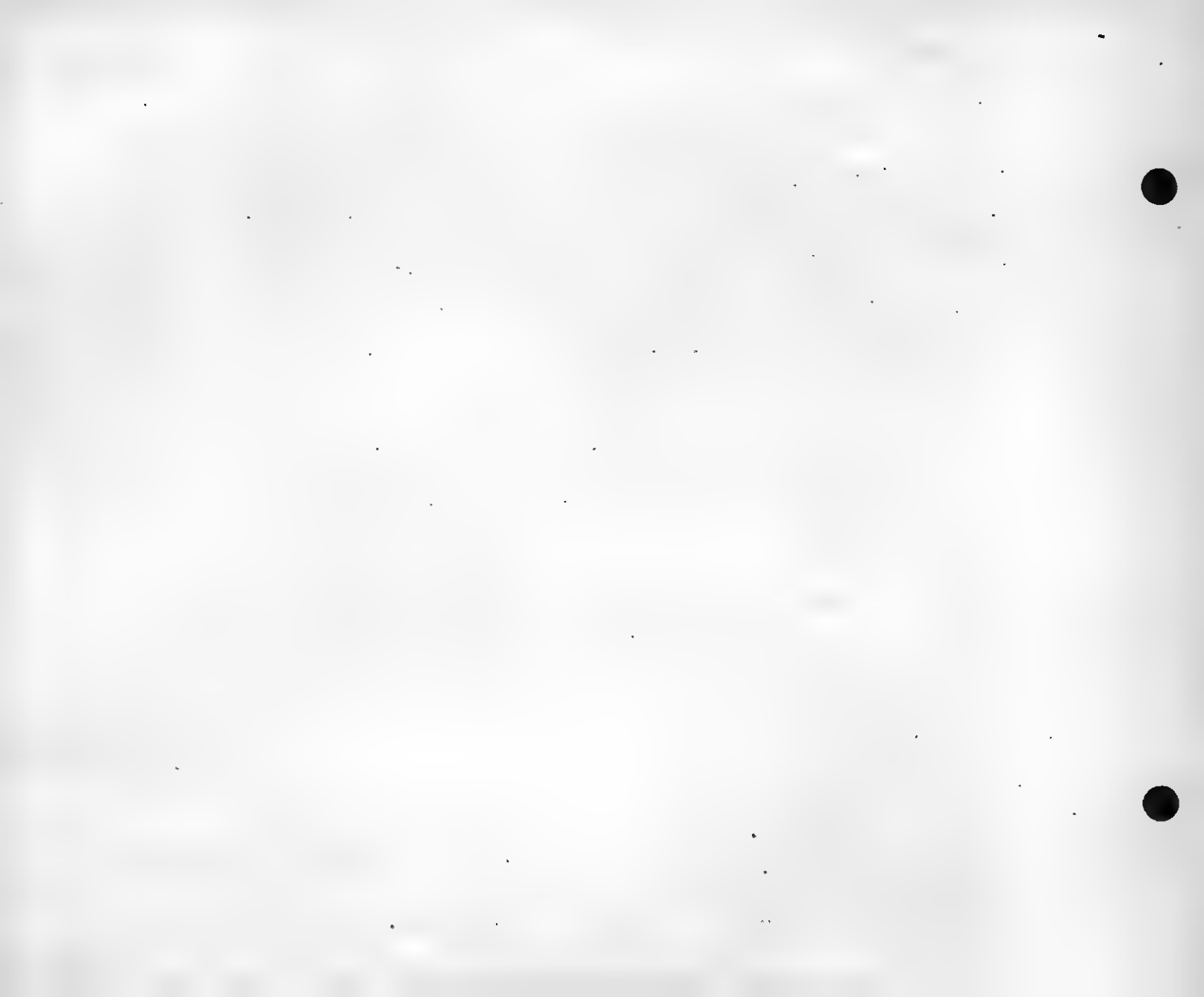
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>1 (M)</p> <p>08730</p> </div> <div> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> </div> <div> <p>08720</p> </div> </div>									
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Montgomery</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u></p> <p>c. LENGTH OF STAY IN ID <u>DOA</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u></p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15-1</p> <p>d. STREET ADDRESS <u>6006 Conway Road</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>				
<p>3. NAME OF DECEASED (Type or print) <u>Due B. Rothkopf</u></p> <p>First Middle Last</p>					<p>4. DATE OF DEATH <u>June 22 1966</u></p> <p>Month Day Year</p>				
<p>5. SEX <u>Female</u></p>		<p>6. COLOR OR RACE <u>white</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>Jan 19, 1904</u></p>		<p>9. AGE (in years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>					<p>10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u></p>				
<p>11. BIRTHPLACE (State or foreign country) <u>Acacia Church, Virginia</u></p>					<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>				
<p>13. FATHER'S NAME <u>Rudolph Francis Bartle</u></p>					<p>14. MOTHER'S MAIDEN NAME <u>Martha Cord Michburn</u></p>				
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)</p>					<p>16. SOCIAL SECURITY NO. <u>Unknown</u></p>				
<p>17. INFORMANT <u>Sister</u> Address <u>4702 Down Rd. Washington D.C. 20016</u></p>					<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u></p> <p>443X DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO</p> <p>(c)</p>				
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>					<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>				
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>					<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>				
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. 19 p.m.</p>			<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>		
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>									
<p>ACTUAL SIGNATURE <u>John G. Ball</u></p>					<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>				
<p>EXAMINER'S NAME (Type) <u>JOHN G. BALL</u></p>					<p>22. DATE SIGNED <u>6/22/66</u> Address (Street, city, town, or county) <u>Bethesda, Md.</u></p>				
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>			<p>23b. DATE THEREOF <u>6-27-66</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u></p>		<p>23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u></p>		
<p>24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, , Bethesda, Maryland</u></p>					<p>25a. REC'D BY REGISTRAR <u>JUN 24 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

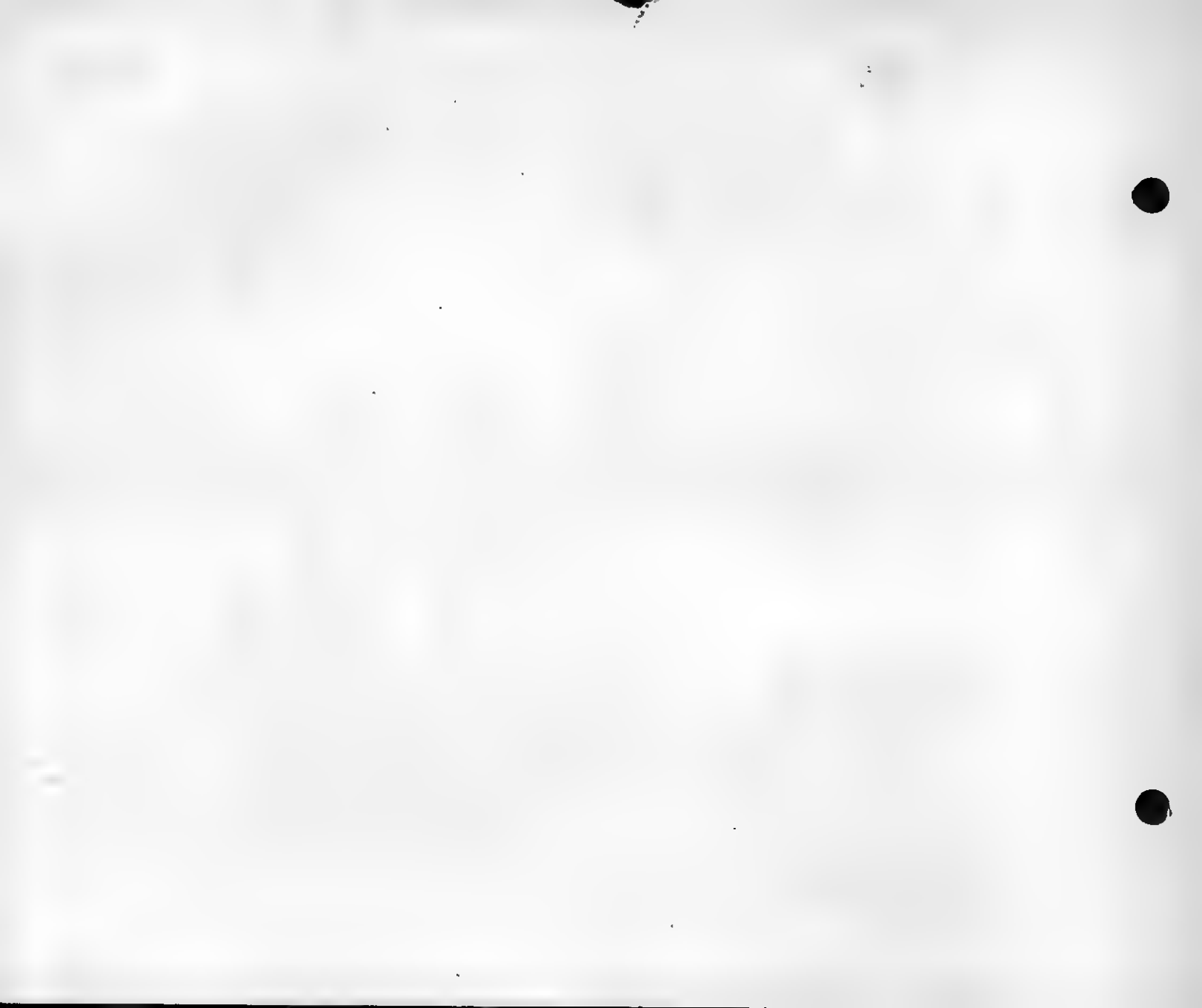
VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08721

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN TB <u>10 days.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>2320 East Gate Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Agnes</u> Last <u>ROWE</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>20</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-22-1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (In years last birthday) yrs <u>71</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Boston, Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel J. Leary</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Mahoney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO <u>176-07-8939</u>	
17. INFORMANT <u>Son - Frederick R. Rowe. (Same as above)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 d</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <u> </u> at work <u> </u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u> </u> to <u>6-20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-20</u> , 19 <u>66</u> , and that death occurred at <u>230</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>D.L. Bucy</u>		22b. DATE SIGNED <u>6-20-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>D.L. Bucy</u>		22d. ADDRESS <u>809 VCIR's Mill Rd Rockville Md. 20850</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 23, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>JUN 22 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

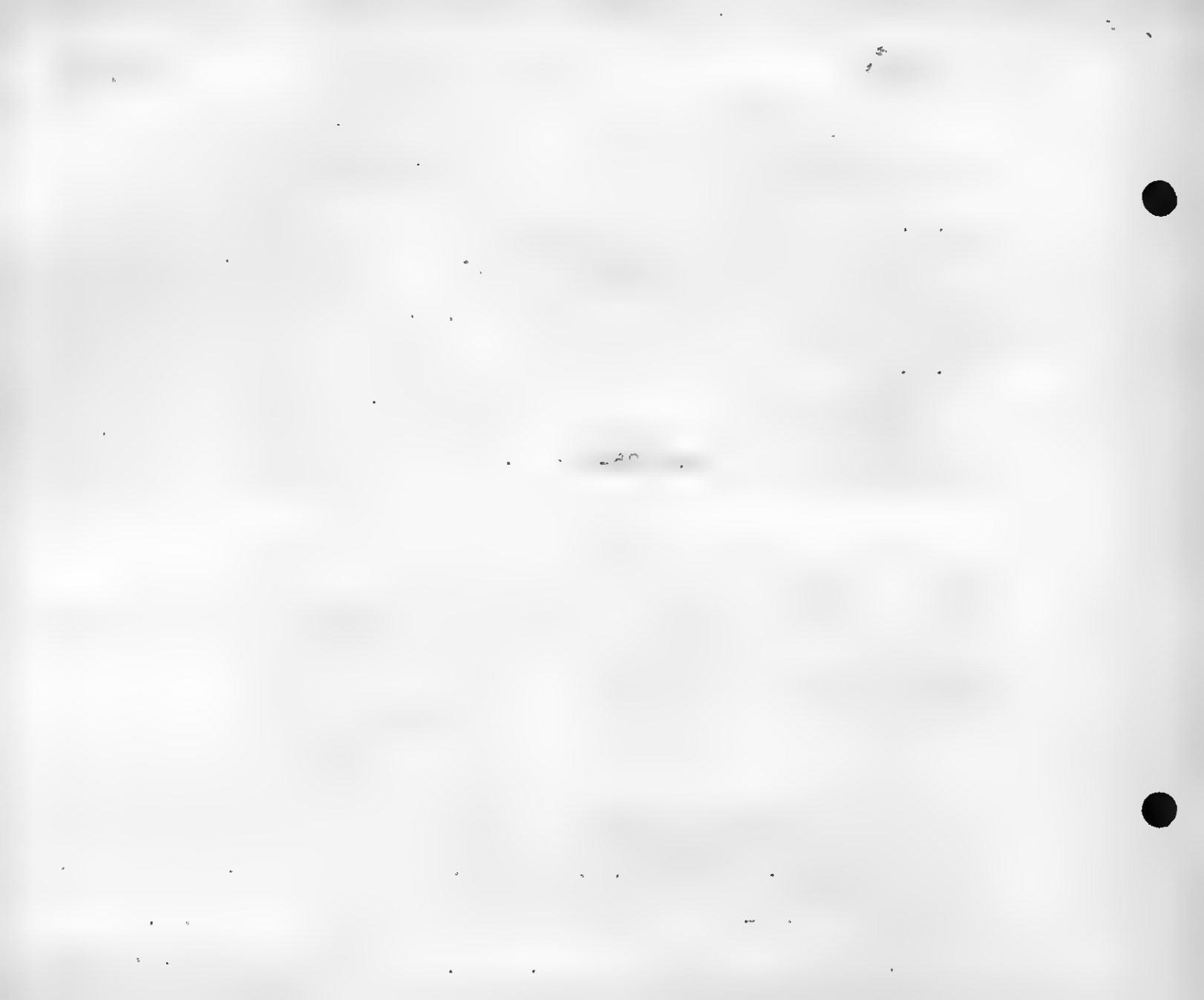
08732

08722

1 PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Rhode Island b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS Bayview Park	
3 NAME OF DECEASED (Type or print) First Martin Middle ROZEN Last ROZEN		4. DATE OF DEATH Month June Day 16 Year 1966	
5 SEX male	6 COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 15, 1893
9 AGE (In years last birthday) yrs 73		10. IF UNDER 1 YEAR Months 4 Days 7 Hours Min 	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Chelsea, Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Isaac Rozen		14. MOTHER'S MAIDEN NAME Anna Rosenberg	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes unknown		16 SOCIAL SECURITY NO. 023-05-7677	
17. INFORMANT Boston Address Mass.		18. Mr. Nathan Rozen, 145 Pinkney Street/	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia associated with DUE TO metastatic reticulum cell sarcoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from May 8 , 19 66 , to June 16 , 19 66 , that (X) (we) last saw the deceased alive on June 16 , 19 66 , and that death occurred at 6:45 A. M., from causes and on the date stated above.			
22a SIGNATURE James L. Shumaker		22b. DATE SIGNED June 16, 1966	
22c. PHYSICIAN'S NAME (Type) James L. Shumaker, M. D.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Transit		23b. DATE THEREOF 6-17-66	
23c. NAME OF CEMETERY OR CREMATORY Swan Point Crematory		23d. LOCATION (City or Town) (County) (State) Providence, R. I.	
24 FUNERAL DIRECTOR Robert A. Pumphrey, 7557 Wisconsin Ave. / Md.		25a. REC'D BY REGISTRAR JUN 20 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

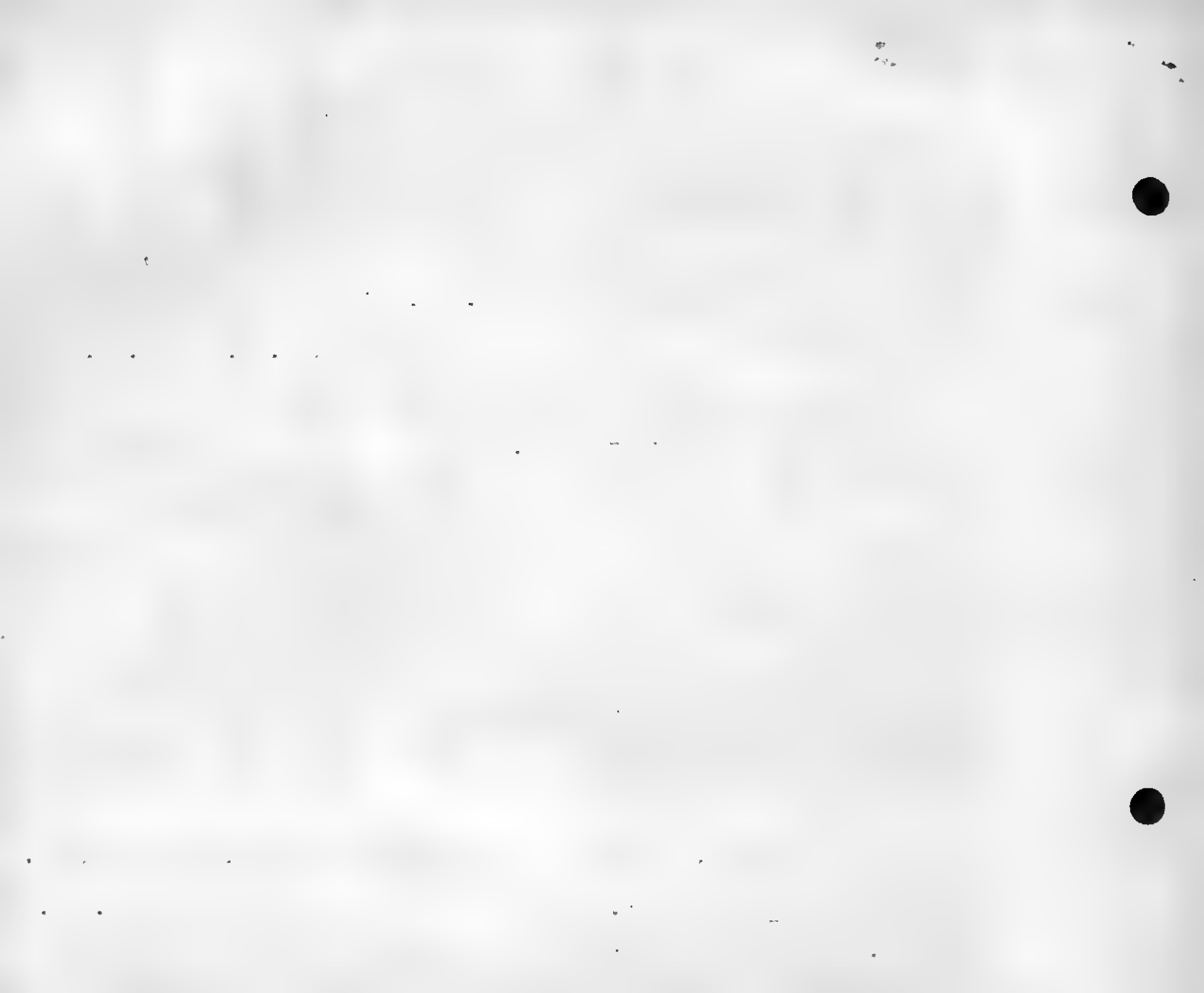
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please staple carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

08733

08723

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bethesda-Silver Spring Nursing Home				d. STREET ADDRESS 5510 Lincoln Street			
3. NAME OF DECEASED (Type or print) First URSULA Middle POOLE Last RUSSELL				4. DATE OF DEATH Month June Day 1 Year 19 66			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 24, 1884	
9. AGE (In years last birthday) 81 yrs.		10. FUNERAL 1 YEAR Months 6 Days 7 Hours Min. 		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY 			
13. FATHER'S NAME Lawson Poole				14. MOTHER'S MAIDEN NAME Elizabeth Boswell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 577-01-3440			
17. INFORMANT W.R. Poole				18. ADDRESS 10024 Sinnott Drive Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral arteriosclerosis (c) INTERVAL BETWEEN ONSET AND DEATH 11 days years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State) 				21. I certify that (I) (this hospital) attended the deceased from May 22, 1966 to June 1, 1966 , that (I) (we) last saw the deceased alive on May 31, 1966 and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert N. Coale				22b. DATE SIGNED June 1, 1966			
22c. PHYSICIAN'S NAME (Type) ROBERT N. COALE				22d. ADDRESS 4429 Bradley Lane, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-3-66			
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION (City, town or county) (State) Prince George Co., Md.			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY				25a. REC'D BY REGISTRAR JUN 3 1966			
25b. REGISTRAR'S SIGNATURE Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08734 CERTIFICATE OF DEATH 08724

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON d. STREET ADDRESS 10404 MUIER PLACE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First JACOB Middle J. Last SCHLEIFER		4. DATE OF DEATH Month JUNE Day 19 Year 1966		5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 13, 1887		9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 8 Days 6 Hours Min. 		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INTERIOR DECORATOR				10b. KIND OF BUSINESS OR INDUSTRY *****				11. BIRTHPLACE (County & State, or foreign country) NEW YORK				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME MICHAEL SCHLEIFER								14. MOTHER'S MAIDEN NAME ROSE KRETT											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WWI				16. SOCIAL SECURITY NO. 579-24-4131				17. INFORMANT Wife Address 10404 Muier Pl Kensington Md.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4201 DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 4 years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from May 1965 , to June 19, 1966 , that (I) (we) last saw the deceased alive on June 18, 1966 , and that death occurred at 9:00 AM , from the causes and on the date stated above.																			
22a. SIGNATURE J. Blaine Fitzgerald M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22b. DATE SIGNED 6-19-66							
22c. PHYSICIAN'S NAME (Type) J. BLAINE FITZGERALD												22d. ADDRESS 8218 Wisconsin Ave. Bethesda							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 6-21-1966				23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL				23d. LOCATION (City, town or county) (State) ARLINGTON VA.							
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY ADDRESS 7557 WISCONSIN AVE BETHESDA, MARYLAND												25a. REC'D BY REGISTRAR JUN 21 1966 DATE				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
08735		08725									
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9039 Sligo Creek Parkway						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 9039 Sligo Creek Parkway					
3. NAME OF DECEASED (Type or print) CELIA						4. DATE OF DEATH Month June Day 14 Year 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 1883		9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (Country & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin Coopersmith						14. MOTHER'S MAIDEN NAME Froma Bronstein					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. 578 16 0618					
17. INFORMANT Daughter						Address See Above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 5410 DUE TO Upper GI bleeding due to duodenal ulcer Conditions, if any, which gave rise to immediate cause (b) } DUE TO (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH 3-4 hours					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) A.S.A.D. - coronary insuff. Pul. fibrosis											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1958 to 6/14 , 19 66 , that (I) (we) last saw the deceased alive on 2/15 , 19 65 , and that death occurred at 3A.M. from the causes and on the date stated above.											
22a. SIGNATURE Herbert Wechsler M.D.						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) Herbert Wechsler						22d. ADDRESS 1800 Eye St. N.W. Wash DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-15-66		23c. NAME OF CEMETERY OR CREMATORY National Capital Hebrew				23d. LOCATION (City, town or county) (State) Washington, DC	
24. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons						25a. REC'D BY REGISTRAR JUN 16 1966					
ADDRESS Washington DC						25b. REGISTRAR'S SIGNATURE Charles Judge					

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08736

05726

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>6 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hattie Irena Simcox</u>		4. DATE OF DEATH Month Day Year <u>June 7 1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-20-88</u>	9. AGE (In years last birthday) <u>78</u> yrs	IF UNDER 1 YEAR Months Days Hours Min. <u>7</u> <u>1966</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>Harvey Hayes</u>		14. MOTHER'S MAIDEN NAME <u>AMY Anne Handy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Records - Washington San & Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Disease - Arteriosclerosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Acute pulmonary-passive congestion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>more than 1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 7, 1966</u> , to <u>June 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 7, 1966</u> , and that death occurred at <u>9:20 P.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>Albert H. Grollman M.D.</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>6/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN, M.D.</u>		22d. ADDRESS <u>1106 SPRING ST. SPRINGFIELD, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JUNE 10, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cleghorn Valley Cemetery</u>	
23d. LOCATION (City or town)		(County)		(State) <u>Springfield, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph L. Lynam Home</u>		ADDRESS <u>Manor</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JUL 5 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

Dr. Belton Reap can be contacted concerning this death and he authorized me to sign this certificate. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove pages 1 and 2 and in any event within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 (M)

08737

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
c. LENGTH OF STAY IN 1b 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
d. STREET ADDRESS 8101 EASTERN AVE

3. NAME OF DECEASED (Type or print) First Middle Last JANICE Catherine SIMPSON
4. DATE OF DEATH Month Day Year 6 4 1966

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH 2/26/09 9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR Months Days Hours Min. 5 7 0 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PERSONAL Mgr Specialist H & Welfare 10b. KIND OF BUSINESS OR INDUSTRY St. Louis, Missouri 11. BIRTHPLACE (County & State, or foreign country) U. S. A. 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Thomas Simpson 14. MOTHER'S MAIDEN NAME Elizabeth Penny

15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN None 16. SOCIAL SECURITY NO. 578-32-5138 17. INFORMANT Address 8101 Eastern Avenue Helen P. Simpson Silver Spring, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
-- in --
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Hypertension (c) Cerebro-sclerosis
INTERVAL BETWEEN ONSET AND DEATH 60 hours Undetermined Undetermined

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 22, 1959, to June 4, 1966, that (I) (we) last saw the deceased alive on June 3, 1966, and that death occurred at 7 M, from the causes and on the date stated above.

22a. SIGNATURE George L Ball 22b. DATE SIGNED June 4, 1966
22c. PHYSICIAN'S NAME (Type) George L Ball 22d. ADDRESS 10620 Georgia Ave Silver Spring, Md

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF June 8, 1966 23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery 23d. LOCATION (City, town or county) (State) St. Louis, Missouri

24. FUNERAL DIRECTOR Ellen Carter 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Maryland 25a. REC'D BY REGISTRAR JUN 10 1966 25b. REGISTRAR'S SIGNATURE Charles Judge

VR A15 (4)
20M 1/65



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
08738					08728									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		a. STATE			b. COUNTY						
Montgomery			BETHESDA		Virginia			Norfolk						
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS						
30 days			The Clinical Center, Bethesda, Maryland		Norfolk			1415 Lead Street						
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
Dorothy Mae Smallwood					June 17 1966									
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.						
Female		Negro				30 September 1925		40 yrs. Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?						
Housewife				----		North Carolina		USA						
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
Tommy Bond					Cassinda (Unknown)									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address				
No					None					The Medical Records				
										The Clinical Center, Bethesda, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia										2 weeks				
DUE TO (b) Hydronephrosis and Hydroureter										2-3 months				
DUE TO (c) Carcinoma of the Cervix										3 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
19														
21. I certify that ID (this hospital) attended the deceased from 18 May, 1966, to 17 June, 1966, that ID (we) last saw the deceased alive on 17 June 1966, and that death occurred at 1:45 M, from the causes and on the date stated above.														
22a. SIGNATURE										22b. DATE SIGNED				
Joseph C. Farmer, Jr., M.D.										June 18, 1966				
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS				
Joseph C. Farmer, Jr., M.D.										The Clinical Center, National Institutes of Health, Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)						
Burial			June 22, 1966		Cedar Landing			Windsor, N. C.						
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Riddick Funeral Service, 1036 Chapel Norfolk, Va.					JUN 21 1966		Charles Judge							



08739

CERTIFICATE OF DEATH

08729

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 536 Beall Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Susie Estelle Smith		4. DATE OF DEATH Month Day Year June 25 1966	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 July 1914
9. AGE (In years lost birthday) yrs. 51		10. IF UNDER 1 YEAR Months Days Hours Min. 51	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C&P Telephone Co.		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Carolina County, Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Woodford Hilton Sirles		14. MOTHER'S MAIDEN NAME Mary Laura Pugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 223 09 1344	
17. INFORMANT Thomas R. Smith		17. ADDRESS 536 Beall Ave. Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) subarachnoid hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 23 , 1966, to June 25 , 1966, that (I) (we) last saw the deceased alive on June 25 , 1966, and that death occurred at 12:25 P.M. on the date stated above.			
22a. SIGNATURE <i>G.W. West</i>		22b. DATE SIGNED June 25, 1966	
22c. PHYSICIAN'S NAME (Type) G.W. West M.D.		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 29, 1966	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR JUN 28 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

CERTIFICATE OF DEATH

08740

08730

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		d. STREET ADDRESS <u>10126 Greenock Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. + Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Harold</u> Middle <u>Smith</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 10, 1903</u>
9 AGE (in years last birthday) <u>62</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Wales</u>	
12 CITIZEN OF WHAT COUNTRY? <u>Amer.</u>		13. FATHER'S NAME <u>William F. Smith</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah Tuckwell</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO		17 INFORMANT <u>Record-Washington San. + Hosp. Takoma Park, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral infarction</u> DUE TO <u>Cerebral vascular thrombosis, deep</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Arteriosclerosis obliterans</u> (b) <u>Arteriosclerosis obliterans</u> (c) <u>Arteriosclerosis obliterans</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis obliterans</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/26</u> , 19 <u>66</u> , to <u>6/29</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>6/29</u> , 19 <u>66</u> , and that death occurred on <u>6/29</u> , 19 <u>66</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Kenneth Cruze</u> M.D.		22b. DATE SIGNED <u>6/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>KENNETH CRUZE</u>		22d. ADDRESS <u>831 Univ. Blvd. Tak. Park, Md.</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>July 1, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR <u>J. Arthur Walters, 254 Carroll St NW DC</u>		25a. RECEIVED BY REGISTRAR DATE <u>JUL 5 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

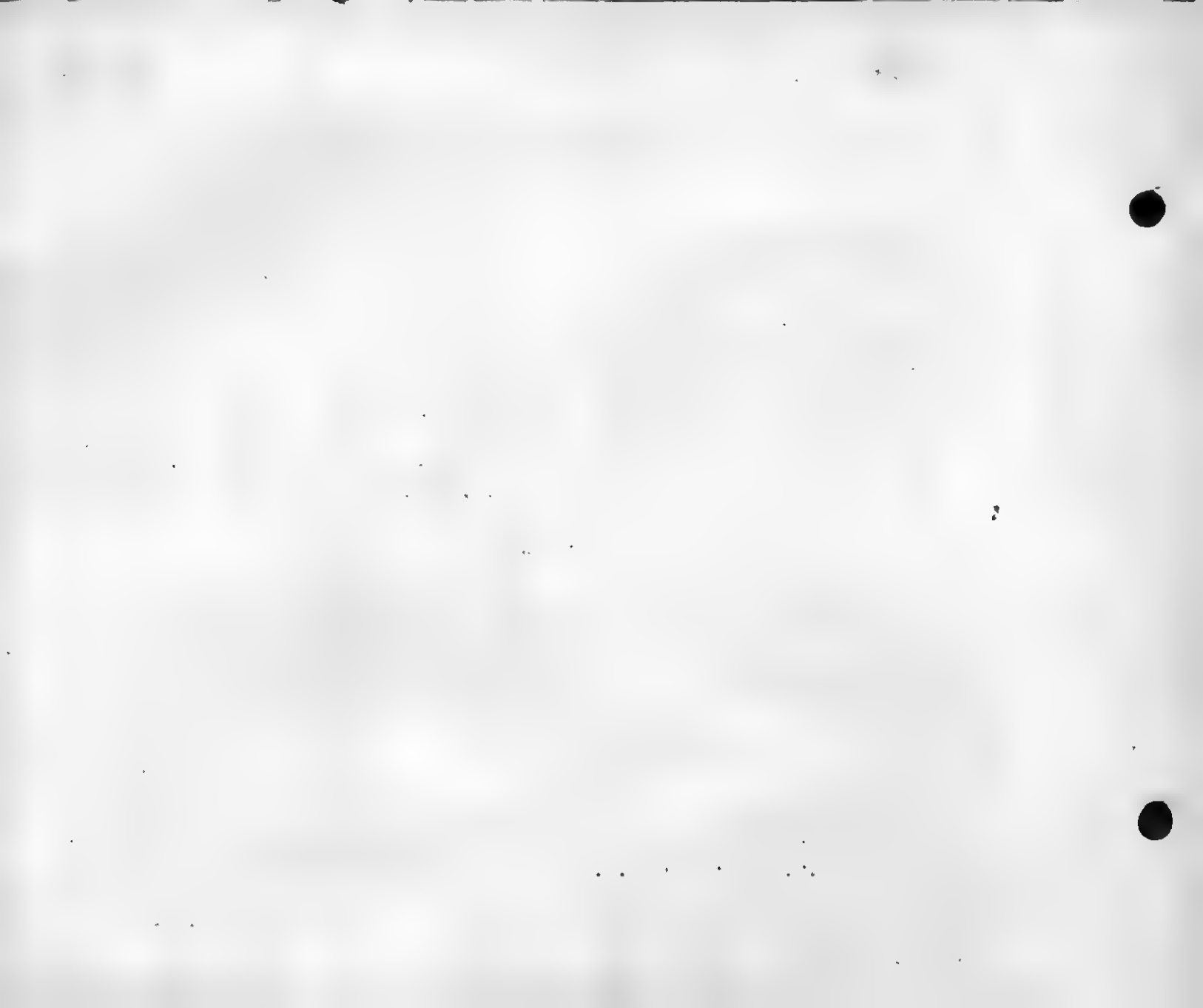
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08731

08731

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>B.</u> Last <u>SNURE</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>29</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-6-77</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert Turner</u>		14. MOTHER'S MAIDEN NAME <u>Anne Brownlie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Robert J. Snure</u>		Address <u>10004 Markham St. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary occlusion</u> DUE TO (c) <u>Carcinoma of stomach</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/26</u> , 19 <u>66</u> to <u>6/29</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/28</u> , 19 <u>66</u> , and that death occurred at <u>9:25 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>A.F. Thibadeau</u>		22b. DATE SIGNED <u>6/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.F. Thibadeau, M.D.</u>		22d. ADDRESS <u>1011 Glenwood Rd. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 2, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>JUL 5 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00742					08732						
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY in b 56 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Alexandria						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland					d. STREET ADDRESS 7724 Lee Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Evelyn		Middle Priscilla		Last Solga		4. DATE OF DEATH Month June Day 1 Year 19 66			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 October 1916		9. AGE (In years last birthday) 49 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) North Dakota		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Martin Burns					14. MOTHER'S MAIDEN NAME Sarah Sharp						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 502-09-8255		17. INFORMANT The Medical Record The Clinical Center, Bethesda, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X Metastatic carcinoma of Pancreas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 Year Gluten sensitive enteropathy DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 7 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from April 6, 1966, to June 1, 1966, that (we) last saw the deceased alive on June 1, 1966, and that death occurred at 2:05 P.M. from the causes and on the date stated above.											
22a. SIGNATURE W. D. Heizer						22b. DATE SIGNED 2 June 1966		22c. PHYSICIAN'S NAME (Type) William D. Heizer, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF June 6, 1966		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town or county) (State) Alexandria, Virginia			
24. FUNERAL DIRECTOR Wm. Demaine & Son Funeral Home				25a. REC'D BY REGISTRAR JUN 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08743

08733

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BURTONSVILLE			c. LENGTH OF STAY IN it 1 1/2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BURTONSVILLE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14612 Perrywood Dr.				d. STREET ADDRESS 14612 Perrywood Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle F. Last SOUTHWELL				4. DATE OF DEATH Month June Day 4 Year 1966			
5. SEX Male		6. COLOR OR RACE caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 26, 1877	
9. AGE (In years last birthday) 89 yrs.		10a. USUAL OCCUPATION (Give kind of work done during major part of time, even if retired) Retired Farm Executive		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State or foreign country) Brooklyn, New York	
12. CITIZEN OF WHAT COUNTRY USA				13. FATHER'S NAME Henry Southwell (deceased)			
14. MOTHER'S MAIDEN NAME Jane Kavit (deceased)				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			
16. SOCIAL SECURITY NO 086-07-7979				17. INFORMANT Address Mr. Francis Matier, same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> DUE TO (b) <u>carcinoma prostate</u> DUE TO (c) <u>years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>generalized arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19__		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>65</u> , to <u>June</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-2</u> , 19 <u>66</u> , and that death occurred at <u>9 P.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>J. Joseph Collins</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-4-66	
22c. PHYSICIAN'S NAME (Type) J. JOSEPH COLLINS				22d. ADDRESS 614 Main St. Laurel, Md.			
23a. BURIAL, CREMATION, REMAINS (Specify) BURIAL		23b. DATE THEREOF June 13, 1966		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery,		23d. LOCATION (City or Town) (County) (State) Valhalla, New York	
24. FUNERAL DIRECTOR ADDRESS Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland				25a. REC'D BY REGISTRAR DATE JUN 9 1966		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08734

08734

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tol, give street address) <u>Durham Hospital</u>				d. STREET ADDRESS <u>8758 Georgia Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edith</u> First <u>GORSUCH</u> Middle <u>Spicknell</u> Last				4. DATE OF DEATH <u>June</u> Month <u>23</u> Day <u>19</u> Year <u>66</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-21-1896</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State or foreign country) <u>Balto. Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James Thomas Gorsuch</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Garrett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Dr. John T. Spicknell Jr. Metuchen, N.J.</u> Address <u>22 Concord Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per life for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>arteriosclerotic coronary disease</u> (b) <u>diabetes mellitus</u> DUE TO <u>unknown</u> (c) <u>unknown</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/21/66</u> , 19 <u>66</u> , to <u>6/23/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/23/66</u> , and that death occurred at <u>2:15</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Jay R. Shapiro MD</u>				22b. DATE SIGNED <u>6/25/66 Bethesda</u>			
22c. PHYSICIAN'S NAME (Type) <u>Jay R. Shapiro</u>				22d. ADDRESS <u>8218 Wisconsin Ave</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 25, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUN 27 1966</u>							



CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTRY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 7	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK 15-1		d. STREET ADDRESS 8106 GARLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANITARIUM HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANNA NMD SPITZMILLER		4. DATE OF DEATH Month Day Year 26/27/66 1964	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/94
9. AGE (In years last birthday) 92 yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (County & State, or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME JOHN ECKSTEIN		14. MOTHER'S MAIDEN NAME JANE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 0113422	
17. INFORMANT MISS ANNA SPITZMILLER DAUGHTER		Address SAME AS DECEASED	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH June 23 June 27	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Uremia & Coma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 23, 1966 , to June 27, 1966 that (I) (we) last saw the deceased alive on June 27, 1966 , and that death occurred at 845 P.M. from causes and on the date stated above.			
22a. SIGNATURE Wilford D. Meyers M.D.		22b. DATE SIGNED June 27, 1966	
22c. PHYSICIAN'S NAME (Type) Wilford D. Meyers M.D.		22d. ADDRESS 8323 Haddon Dr. Takoma Park Md	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF June 30, 1966	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City or Town) (County) (State) Washington D.C.
24. FUNERAL DIRECTOR Arthur Walters		25. DEED BY REGISTRAR Charles Judge	
25a. ADDRESS 254 Carroll Street NW Washington, D.C. 20001		25b. REGISTRAR'S SIGNATURE Charles Judge	



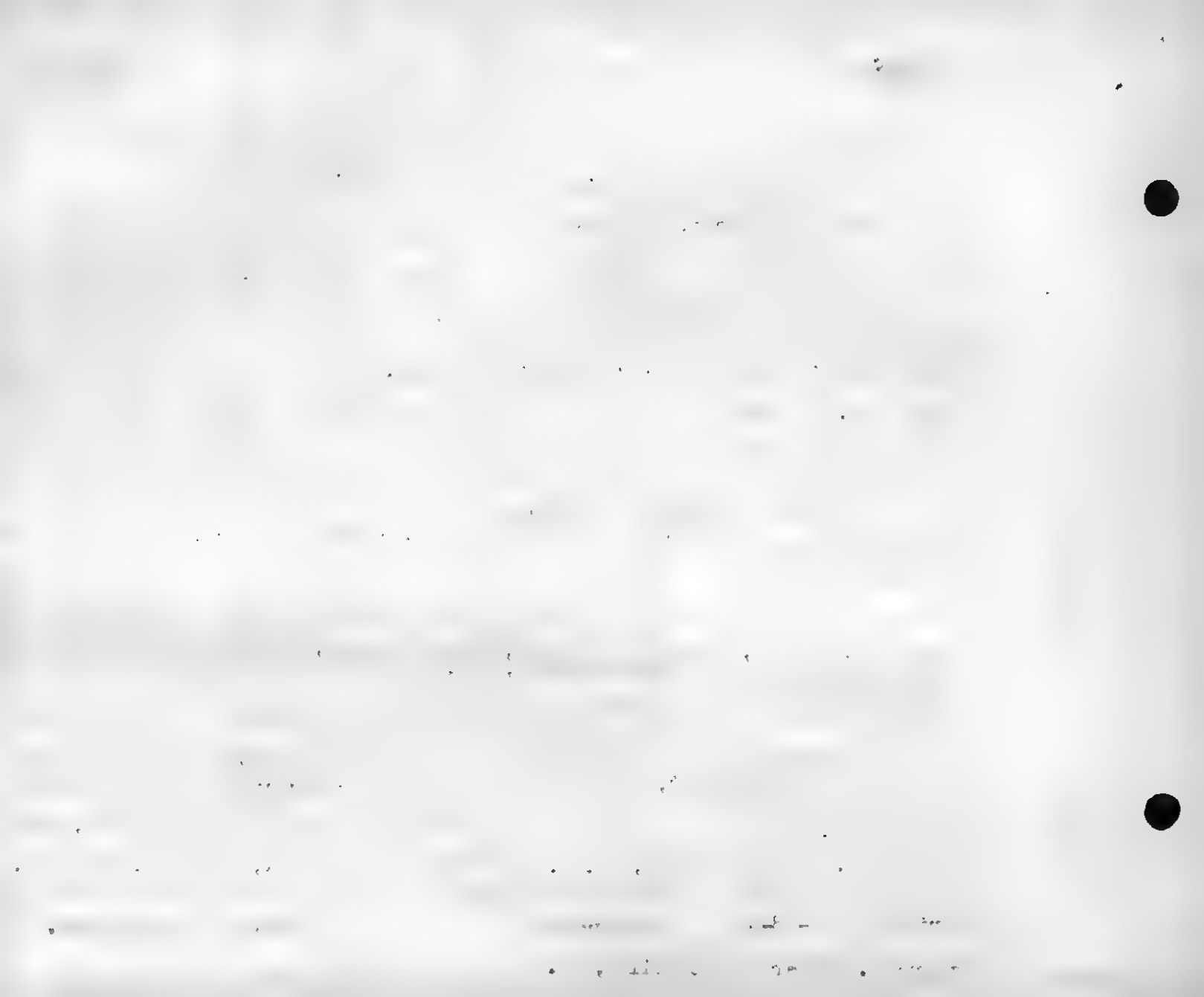
CERTIFICATE OF DEATH

08736

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenwood	
c. LENGTH OF STAY in 1b 5 days		d. STREET ADDRESS Montgomery General Hospital	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Henry Stinson	4. DATE OF DEATH Month June Day 25 Year 1966		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/95
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer & garage owner		10b. KIND OF BUSINESS OR INDUSTRY farm and garage	
11. BIRTHPLACE (County & State, or foreign country) Howard, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME William H. Stinson		14. MOTHER'S MAIDEN NAME Estelle Roane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Arteriosclerotic Cardio-vascular-renal Disease DUE TO (c) 10 yrs plus		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus, Cirrhosis of Liver, Cholelithiasis, Multiple		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) On injury		20b. HONORABLE CAUSE (Enter nature of injury in Part I or Part II of item 18) On injury	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) On injury	20f. (City or town) (County) (State) On injury
21. I certify that (I) (the doctor) attended the deceased from More than 20 yrs to 6/28/66 , 19__, that (I) (we) saw the deceased alive on June 28, 1966 , and that death occurred at 10:17 P.M. 25 M, from causes and on the date stated above.			
22a. SIGNATURE M. McKendree Boyer		22b. DATE SIGNED June 26, 1966	
22c. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M. D.		22d. ADDRESS 9701 Church Street, Damascus, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-28-66	23c. NAME OF CEMETERY OR CREMATORY Oak Grove	23d. LOCATION (City or Town) (County) (State) Glenwood Howard Md.
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.		25a. REC'D BY REGISTRAR JUN 29 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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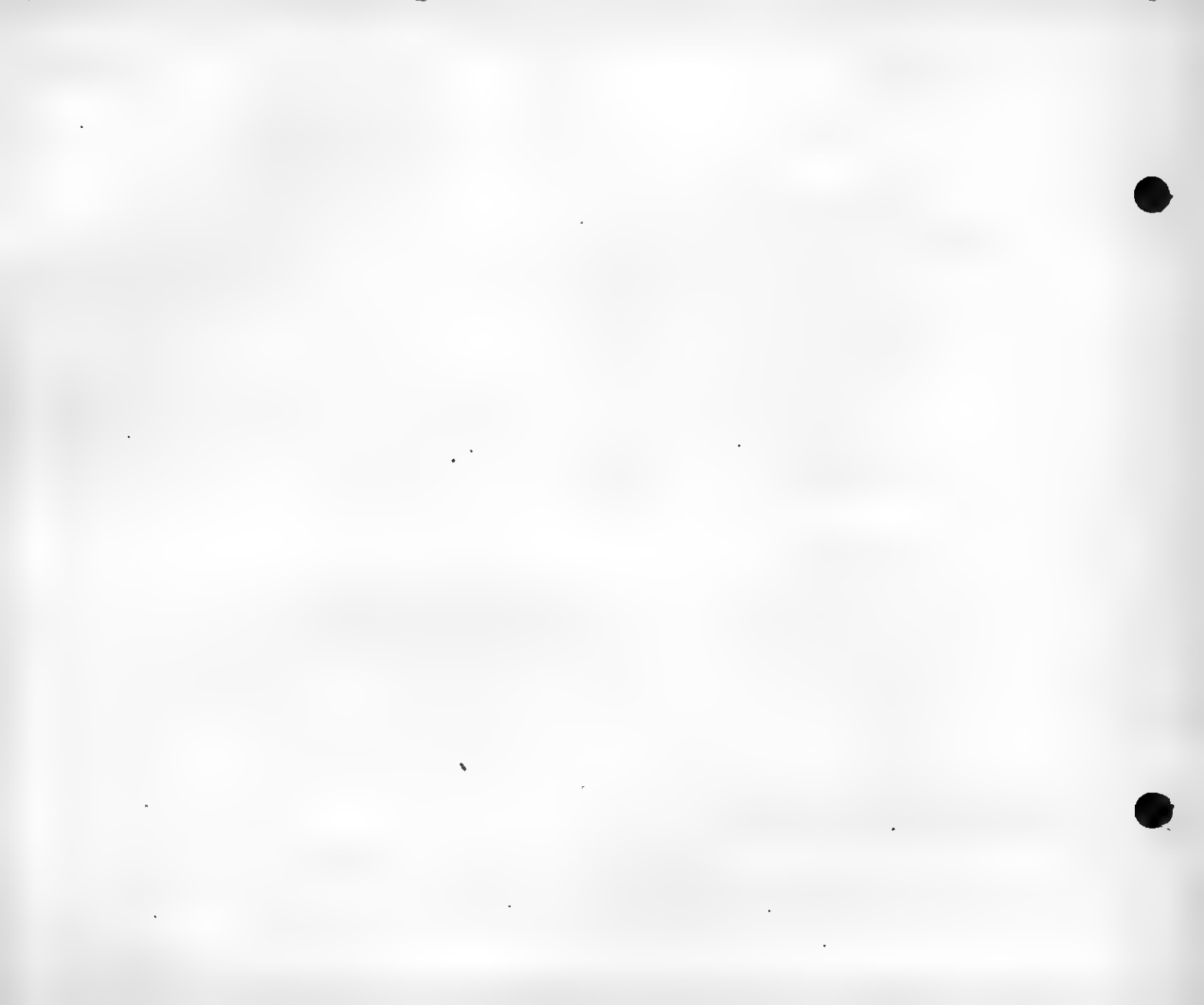
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>11603 Idlewood Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Mildred U. Strippey</u>		4. DATE OF DEATH <u>June 19 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-2-95</u> 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (Housewife)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-20-0256</u>	
17. INFORMANT <u>EUGENE A. STRIPPEY</u>		Address <u>4703 HIGHWOOD DR SILVER SPRING MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IRREVERSIBLE Shock</u> DUE TO (b) <u>acute Pancreatitis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ARTERIOsclerotic heart Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/15</u> , 19 <u>66</u> , to <u>6/19</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/19</u> , 19 <u>66</u> , and that death occurred at <u>3:45</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Raymond T. Benack</u>		22b. DATE SIGNED <u>6/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND T. BENACK MD</u>		22d. ADDRESS <u>4115 Colie Drive, Wheaton, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6/22/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS</u>	23d. LOCATION (City, town or county) (State) <u>HARPERS FERRY WVA</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers Co</u> ADDRESS <u>8655 Ga. Ave S.I. Sping, Md.</u>		25a. REC'D BY REGISTRAR <u>J Charles Judge</u> 25b. REGISTRAR'S SIGNATURE	



CERTIFICATE OF DEATH

08748

08738

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HOWARD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>				d. STREET ADDRESS <u>Kerger Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Viola</u> Last <u>Strother</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>9</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-85</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Charles P. Bailey</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Best</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Chart</u>		17. INFORMANT <u>Chart</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac failure, acute + chronic</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Chronic pyelonephritis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2-6 mos.</u> <u>2-4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral vascular accidents, recurrent</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <u>Charles R. Shultz MD</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-9-66</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 12, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rosedale Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Martinsburg W. Va.</u>	
24. FUNERAL DIRECTOR <u>McKitt Carradine, Laurel, Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3500 4-64

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairway Hills c. LENGTH OF STAY IN 1b ?? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6300 Crathie Lane		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairway Hills d. STREET ADDRESS 6300 Crathie Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN GUICE SUTTON		4. DATE OF DEATH June 20, 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1902
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR: Months 11 Days 14 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Gov't	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Stephen Sutton		14. MOTHER'S MAIDEN NAME Ada Collins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 577-60-0650	
17. INFORMANT Wife		Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency, Acute + 201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/> June 20, 1966 M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Bethesda, Md.	
EXAMINER'S NAME (Type) JOHN G. BALL		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/23/1966	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City, town or county) (State) Washington D. C.
24. FUNERAL DIRECTOR Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
25a. REC'D BY REGISTRAR JUN 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

00750

CERTIFICATE OF DEATH

08740

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MONTGOMERY</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>CRUICKSHANK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Stone Ridge Ct</u>	
3. NAME OF DECEASED (Type or print) First <u>DAISY</u> Middle <u>H</u> Last <u>SWEADNER</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 21 - 1888</u>
9. AGE (In years last birthday) yrs <u>78</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Utica Frederick Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN HOLTZOPLE</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE LONG</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>220-03-5895</u>	
17. INFORMANT <u>LOUIS E SWEADNER</u>		Address <u>71</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1963</u> , to <u>6-13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>MAY 1966</u> , and that death occurred at <u>11:18</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>D.L. Bucy</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>D.L. Bucy</u>		22d. ADDRESS <u>809 Veirs Mill Rd Rockville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/16/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FAIRMOUNT</u>		23d. LOCATION (City or Town) (County) (State) <u>LIBERTYTOWN MD</u>	
24. FUNERAL DIRECTOR <u>D. Hartzler & Sons Libertytown, Md</u>		25a. REC'D BY REGISTRAR <u>DA JUN 17 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00751

CERTIFICATE OF DEATH

05741

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u>	
c. LENGTH OF STAY IN 1b <u>21 days</u>		d. STREET ADDRESS <u>Box 101 Rt # 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Burley Taylor</u>		4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/29/05</u> 9. AGE (In years last birthday) <u>61</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursery</u>	
11. BIRTHPLACE (County & State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Curod</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO <u>414-10-7531</u>	
17. INFORMANT <u>Donald Taylor</u> Address <u>401 Park Rd. Rockville</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4201 DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-19</u> , 19 <u>66</u> to <u>6-9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-9</u> , 19 <u>66</u> , and that death occurred at <u>8:20</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>D.L. Bucy</u>		22b. DATE SIGNED <u>6-9-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>D.L. Bucy</u>		22d. ADDRESS <u>809 Veirs Mill Rd Rockville</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/13/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington Virginia</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUN 13 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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08752

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08742

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>SPOTSYLVANIA</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SITUATIONAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>WELVIN THAXTON</u>		4. DATE OF DEATH <u>JUN 12, 1966</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>NEGRO</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4/19/46</u>
9 AGE (in years lost birthday) <u>20</u> yrs		10 UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TOBACCO WORKER</u>		10b KIND OF BUSINESS OR INDUSTRY <u>FACTORY</u>	
11 BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>WALTER LEE THAXTON</u>		14 MOTHER'S MAIDEN NAME <u>MARY WALTON</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>MOTHER per FLORENCE FULFRAAL HOME 30. BOST.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>fracture, skull, compound, comminuted</u> DUE TO (b) <u>Automobile Accident</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in dump truck turned over and was thrown out.</u>	
20c TIME OF INJURY Month, Day, Year <u>10:45 PM 6-18 1966</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f (City or town) (County) (State) <u>Tripplet Mont. Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John E. Bell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/19/66</u>	
		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b DATE THEREOF <u>6/20/66</u>	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State) <u>South Boston, Va.</u>
24 FUNERAL DIRECTOR <u>Lowes Funeral Home</u>		25 REC'D BY REGISTRAR <u>JUN 22 1966</u>	
ADDRESS <u>1425 Md. Ave, N. E. D.C.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

CE753

08743

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>city</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
c. LENGTH OF STAY IN 1b <u>15 mos.</u>		d. STREET ADDRESS <u>1610 Park Rd, Washington, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chevy Chase Nursing Home, E. W. Highway 2015</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Bertha</u> First Middle Last		4. DATE OF DEATH Month <u>6</u> Day <u>26</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>82</u> yrs.
9. DATE OF BIRTH <u>Dec 25, 1883</u>		10. IF UNDER 1 YEAR Months <u>26</u> Days <u>19</u> Hours <u>66</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Major Bedford</u>		14. MOTHER'S MAIDEN NAME <u>Wiktoria Starodubski</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>123-20-6559A</u>	
17. INFORMANT <u>MRS. JENNE TOURIN</u>		Address <u>611 E. HALBERT RD - BETHESDA - MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>CORONARY Thrombosis</u> DUE TO (c) <u>ARTERIOSCLEROTIC Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>IMMED</u> <u>IMMED</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1948</u> , 19 <u>66</u> , to <u>6-26</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>26-26</u> 19 <u>66</u> , and that death occurred at <u>6 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>William Kurstin MD</u>		22b. DATE SIGNED <u>6/26/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>William Kurstin</u>		22d. ADDRESS <u>915 19th St. N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>6-27-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>F.L. Lincoln Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>COTTAGE CITY MD</u>	
24. FUNERAL DIRECTOR <u>Goldberg, Fun Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>4217 9 St. N.W.</u>		DATE <u>JUN 28 1966</u>	

CERTIFICATE OF DEATH

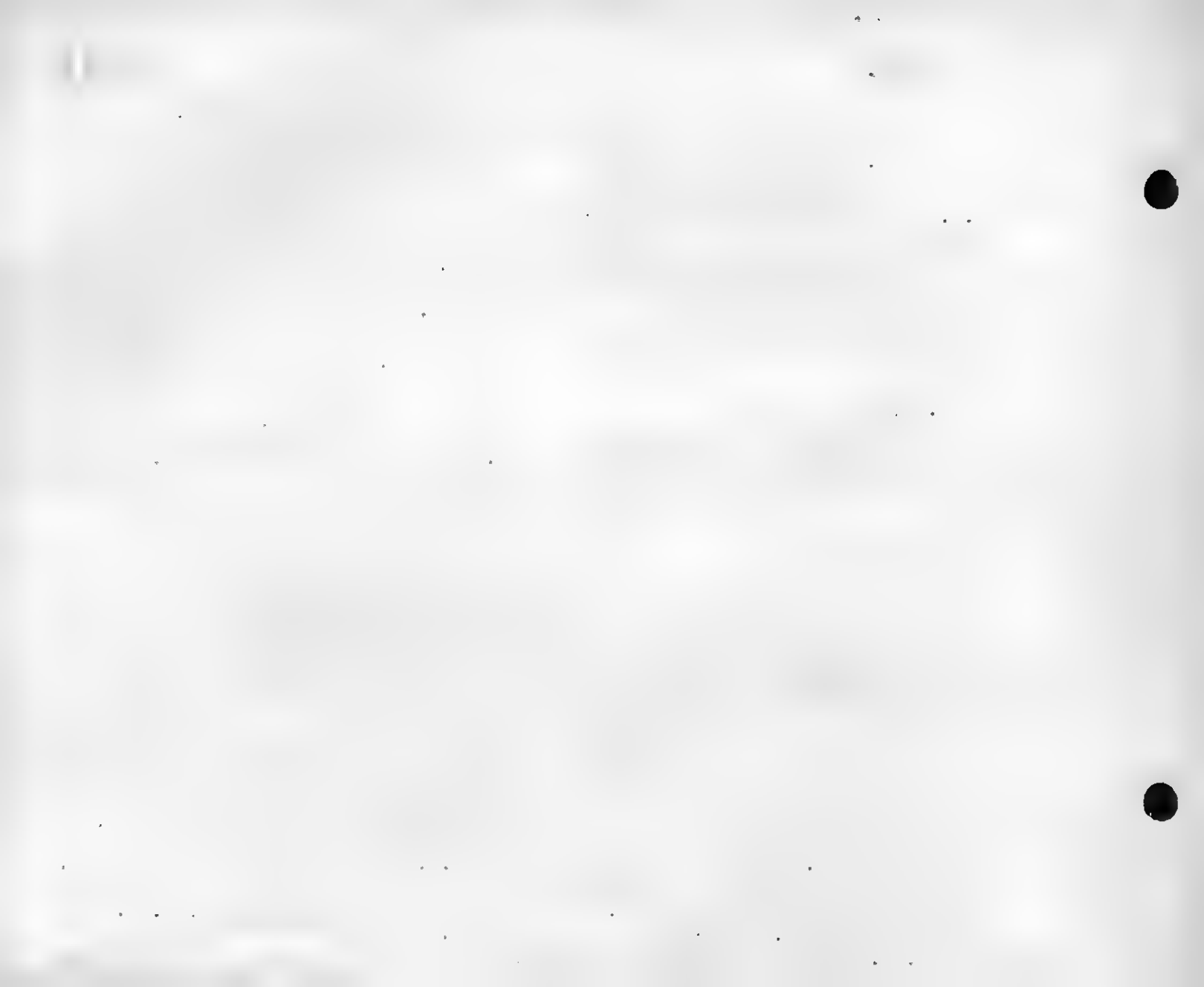
002754

08744

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 125 Southwood Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Lucile Wilson Wahl		4. DATE OF DEATH Month Day Year June 6 1966	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1889
9. AGE (in years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME A. Wilson		14. MOTHER'S MAIDEN NAME Anna Jordon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 577-05-5865 None X	
17. INFORMANT Mr. Richard Wahl		125 Southwood Avenue Silver Spring, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma of lung 165 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 6 , 1966, to June 6 , 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 6 , 1966, and that death occurred at 555P M, from causes and on the date stated above.			
22a. SIGNATURE J. Zimmerman		22b. DATE SIGNED June 7, 1966	
22c. PHYSICIAN'S NAME (Type) J. ZIMMERMAN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF June 8, 1966	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR W. E. Humphrey Funeral Home, 8434 Georgia Ave., Silver Spring, Md.		25a. REC'D BY REGISTRAR JUN 13 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and it is recommended that they be filed within 72 hours after death.



CERTIFICATE OF DEATH

08745

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN lb 117 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY Kansas c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wichita d. STREET ADDRESS 121 S. Tracy Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Darrell Thomas Walker II		4. DATE OF DEATH Month June Day 15 Year 1966	
5. SEX male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 December 1943
9. AGE (In years last birthday) yrs 22		10. IF UNDER 1 YEAR Months 12 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Wichita, Kansas	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Darrell Thomas Walker		14. MOTHER'S MAIDEN NAME Jerry Foraker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1964-1966		16. SOCIAL SECURITY NO 510 38 5794	
17. INFORMANT Wichita, Kansas		18. ADDRESS Mrs. Jerry Hayes 121 S. Tracy St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Lymphoma wide spread Metastasis 2002 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 18, 1966 to June 15, 1966 , that (I) (we) last saw the deceased alive on June 15, 1966 , and that death occurred at 12:15 A.M. from causes and on the date stated above			
22a. SIGNATURE James L Snyder		22b. DATE SIGNED 15 JUNE 1966	
22c. PHYSICIAN'S NAME (Type) J. L. Snyder		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/16/66	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven		23d. LOCATION (City or Town) (County) (State) Wichita, Kansas	
24. FUNERAL DIRECTOR W. W. Chambers		25a. RECORD BY REGISTRAR Washington, D.C. 1400 Chapin St. N. W.	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		DATE JUN 17 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00756

05746

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b 3 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 4 Marigold Ct. Md. b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland		d. STREET ADDRESS 4 Marigold Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ida		First		Middle Walker		Last		4. DATE OF DEATH June 15 1966		Month June	
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/25/1889		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailoring		10b. KIND OF BUSINESS OR INDUSTRY Tailoring Business Clothes		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Moses Pinerman		14. MOTHER'S MAIDEN NAME Sarah Potts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578-49-524		17. INFORMANT Morton Walker		Address Same as 2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X CONGESTIVE FAILURE DUE TO (b) METASTATIC CARCINOMA. DUE TO (c) BREAST CARCINOMA.		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL 1966 , to 6-15-1966 , that (I) (we) last saw the deceased alive on 6-15-1966 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.		22a. SIGNATURE Robert Kramer		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Robert Kramer M. D.		22d. ADDRESS 8484 16th St. 83 Rd.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-17-1966		23c. NAME OF CEMETERY OR CREMATORY Adas Israel Cemetery		23d. LOCATION (City, town or county) (State) Washington D. C.		24. FUNERAL DIRECTOR Oldberg Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		25c. NAME OF CEMETERY OR CREMATORY		25d. LOCATION (City, town or county) (State)		25e. REC'D BY REGISTRAR		25f. REGISTRAR'S SIGNATURE		25g. NAME OF CEMETERY OR CREMATORY	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

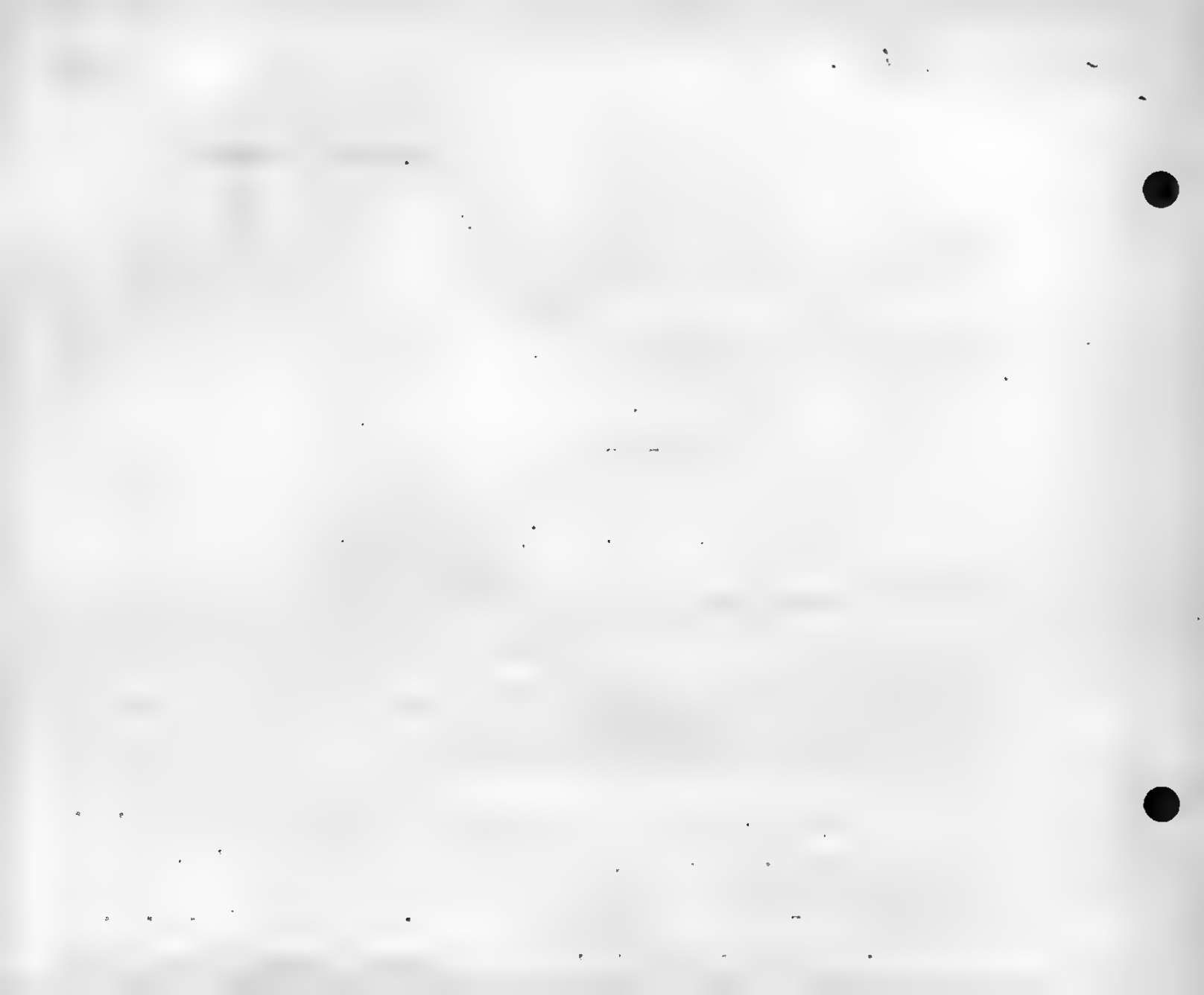
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in-employment within 72 hours after death.

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5M 1/65

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase 20015</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6700 Hillandale Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>KATHERINE G.</u> Middle <u>WALLER</u> Last <u>WALLER</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> LEGAL SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 19 1943</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ALLSCHALMERS</u>	9. AGE (In years last birthday) <u>23</u> yrs. <u>4</u> months <u>16</u> days
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ERNEST A GRAVES</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE KLEE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-38-2935</u>	
17. INFORMANT <u>MOTHER</u>		Address <u>BETHESDA</u> <u>5129 MANNING DR.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: <u>Subarachnoid Hemorrhage.</u> DUE TO <u>Rupture of Aneurysm Anterior Cerebral</u> DUE TO <u>Artery - Congenital</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bethesda, Md.</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/5/66</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-7-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUN 8 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08758

08748

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, D. C.		d. STREET ADDRESS 1613 - 35th Street N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shannon Nursing Home		3. NAME OF DECEASED (Type or print) First Delbert		Middle Moody		Last Wells		4. DATE OF DEATH Month June		Day 1		Year 1966									
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/13/1874		9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months 91		IF UNDER 24 HRS. Days 91		Hours 91							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Builder		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Unobtainable		14. MOTHER'S MAIDEN NAME --Buckingham		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.							
17. INFORMANT Agatha W. Wilken - 1613 35th St. N. W.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerosis DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4-5 days		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JANUARY 6, 1964 to 1 June, 1966 that (I) (we) last saw the deceased alive on 5/28 1966 , and that death occurred at 10:25 PM from the causes and on the date stated above.		22a. SIGNATURE William D. Aud		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) William D. Aud		22d. ADDRESS 9006 Colesville Road Silver Spring Md.		22e. (State)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/3/66		23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		23d. LOCATION (City, town or county) Washington, D. C.		24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company		ADDRESS Washington, D.C.		25a. REC'D BY REGISTRAR JUN 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08759

CERTIFICATE OF DEATH

08749

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Rt #2</u>	
3. NAME OF DECEASED (Type or print) First <u>Stuart</u> Middle <u>C. Whisman</u> Last <u>Whisman</u>		4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/16/12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS, OR INDUSTRY <u>Mont Co. Gov</u>	9. AGE (In years, last birthday) <u>54</u> yrs
11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mauro</u>		14. MOTHER'S MAIDEN NAME <u>Gerlinia Wardell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>20-09-2600 (wife)</u>	
17. INFORMANT <u>Flora Whisman</u>		Address <u>as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary thrombosis</u> DUE TO (b) <u>arterio sclerosis previous infarction</u> DUE TO (c) <u>recent sub-total gastrectomy</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>emphysema advanced</u>			19. WAS A JIPTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/22/66</u> , 19 <u>66</u> , to <u>6/27</u> , 19 <u>66</u> , and that death occurred at <u>2:45</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>John O. Robben</u> M.D.		22b. DATE SIGNED <u>6-27-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John O. Robben MD</u>		22d. ADDRESS <u>10400 CONNECTICUT AVE Kensington</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/1/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>	23d. LOCATION (City or town) (County) (State) <u>Beallsville Montg Md</u>
24. FUNERAL DIRECTOR <u>William B. Hillen</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Barnesville, Md</u>		DATE <u>JUL 5 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN</u>		c. LENGTH OF STAY IN b <u>1 year</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>PRINCE GEORGES</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MARYLAND HOME OF REST, INC.</u>						d. STREET ADDRESS <u>6608 NEWPORT RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAURA REBECCA WHITE</u>						4. DATE OF DEATH Month Day Year <u>6 30 1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1876</u>		9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months Days <u>7 10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ALEXANDRIA, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>James T. Walker</u>						14. MOTHER'S MAIDEN NAME <u>Virginia G. ?</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>						16. SOCIAL SECURITY NO. <u>Robert B. White Sr.</u>					
17. INFORMANT <u>Robert B. White Sr.</u>						18. ADDRESS <u>6608 Newport Rd. Hyattsville, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Enterosclerotic cardiovascular disease</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Chronic glomerulonephritis</u>											
(c) <u></u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. <u>5:20</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>5120</u>		20f. (City or town) <u>Hyattsville</u>		20g. (County) <u>Prince Georges</u>		20h. (State) <u>MD</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> , 19 <u>65</u> to <u>5/30</u> , 19 <u>66</u> , that (I) (we) saw the deceased alive on <u>6/18</u> , 19 <u>66</u> , and that death occurred at <u>11:20 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>James P. Kerr</u>						22b. DATE <u>6/20/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>						22d. ADDRESS <u>DAMASCUS</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 24, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		23d. LOCATION (City, town or county) <u>Arlington</u>		23e. (State) <u>Va</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>						24b. ADDRESS <u>Hyattsville, Md</u>		25. BY REGISTRAR <u>JUN 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM (5)
5M 1/65

FOR STATE
HEALTH DEPT.

CE761

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08752

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		c. LENGTH OF STAY IN 1b <u>D. O. A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
3. NAME OF DECEASED (Type or print) First <u>Francois</u> Middle <u>Turner</u> Last <u>Williams</u>		d. STREET ADDRESS <u>14600 Claude Lane</u>	
5. SEX <u>Male</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. COLOR OR RACE <u>White</u>		4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>19 66</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 6, 1907</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
13. FATHER'S NAME <u>Edward Williams</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		14. MOTHER'S MAIDEN NAME <u>Ella Turner</u>	
16. SOCIAL SECURITY NO. <u>579-24-5308</u>		17. INFORMANT <u>Dorothy E. Williams</u> Address <u>14600 Claude Lane, Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1201 Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Disease.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22. DATE SIGNED <u>6/30/1966</u>	
23b. DATE THEREOF <u>July 2, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>		24. FUNERAL DIRECTOR <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Avenue</u>	
25a. REC'D BY REGISTRAR <u>John B. Thomas</u>		25b. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>	
DATE <u>JUL 5 1966</u>		DATE <u>JUL 5 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08762 CERTIFICATE OF DEATH 08753

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5062 Park Place		d. STREET ADDRESS 5062 Park Place	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle E. Last WISE		4. DATE OF DEATH Month June Day 30 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-13-1901
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Patrick Wise		14. MOTHER'S MAIDEN NAME Mary Emma Burroughs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) - - -		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 579-16-5254	
17. INFORMANT Charles F. Sisson, Wash. D.C.		Address 2754 Woodley Place	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastrointestinal hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Duodenal ulcer DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 11 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Craniotomy for removal brain tumor (May, 1965) & Rt. hemiplegia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-19-1966 to 6-30-1966 that (I) (we) last saw the deceased alive on 6-30-1966 , and that death occurred at 11 M, from the causes and on the date stated above.			
22a. SIGNATURE George A. Gray, Jr.		22b. DATE SIGNED 6/11/66	
22c. PHYSICIAN'S NAME (Type) George A. Gray, Jr.		22d. ADDRESS Cherry Chase, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-4-1966	
23c. NAME OF CEMETERY OR CREMATORY Methodist Church Cemetery, Potomac, Md.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS 150 Wisc. Ave. N.W. Wash. D.C.		DATE JUL 5 1966	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08754

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington</u> COUNTY <u>D.C.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Resmaa Sanatorium</u>		d. STREET ADDRESS <u>6245 30th St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Sue</u> Middle <u>Belle</u> Last <u>Wiseman</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 15, 1882</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		12. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
13. BIRTHPLACE (County & State, or foreign country) <u>Washington D. C.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. FATHER'S NAME <u>Patrick Francis Sheedy</u>		16. MOTHER'S MAIDEN NAME <u>Louisa Lucas</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		18. SOCIAL SECURITY NO. <u> </u>	
19. INFORMANT <u>John C. Wiseman - son</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u>			
(c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure</u>			
(b) <u>Diabetes</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>present</u> , 19 <u> </u> , that (we) last saw the deceased alive on <u>6/3</u> 19 <u>66</u> , and that death occurred at <u>3:13</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>John B. Umhau</u> M.D.		22b. DATE SIGNED <u>6/5/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John B. Umhau</u>		22d. ADDRESS <u>8805 Conn. Ave. Ch. Ch. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>8 June 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOSEPH GAWLERS SONS</u>		25a. REC'D BY REGISTRAR <u>WLN 9</u> 1966	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00764

CERTIFICATE OF DEATH

08755

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN ib	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Sanitarium		d. STREET ADDRESS 4201 Mass. Ave., N.W.	
3. NAME OF DECEASED (Type or print) First Lorena Middle M. Last Witt		4. DATE OF DEATH Month June Day 21 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1891
9. AGE (in years last birthday) yrs 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Arizona		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME E.O. Kennedy,		14. MOTHER'S MAIDEN NAME Elizabeth Phelan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Nellie K. Ferguson,		Address 4201 Mass. Ave. N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary + thrombosis 4201 DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/21, 1966 to 6/21, 1966 that (I) (we) last saw the deceased alive on 6/21, 1966 , and that death occurred at 4:53 AM , from causes and on the date stated above.			
22a. SIGNATURE W. J. Joyce		22b. DATE SIGNED June 21, 1966	
22c. PHYSICIAN'S NAME (Type) W. J. Joyce		22d. ADDRESS 4977 Battery Lane, Bethesda, Md.	
23a. BURIAL (CREMATION, REMOVAL, etc.) Burial	23b. DATE THEREOF June 23, 1966	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR W. J. Joyce		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 24 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

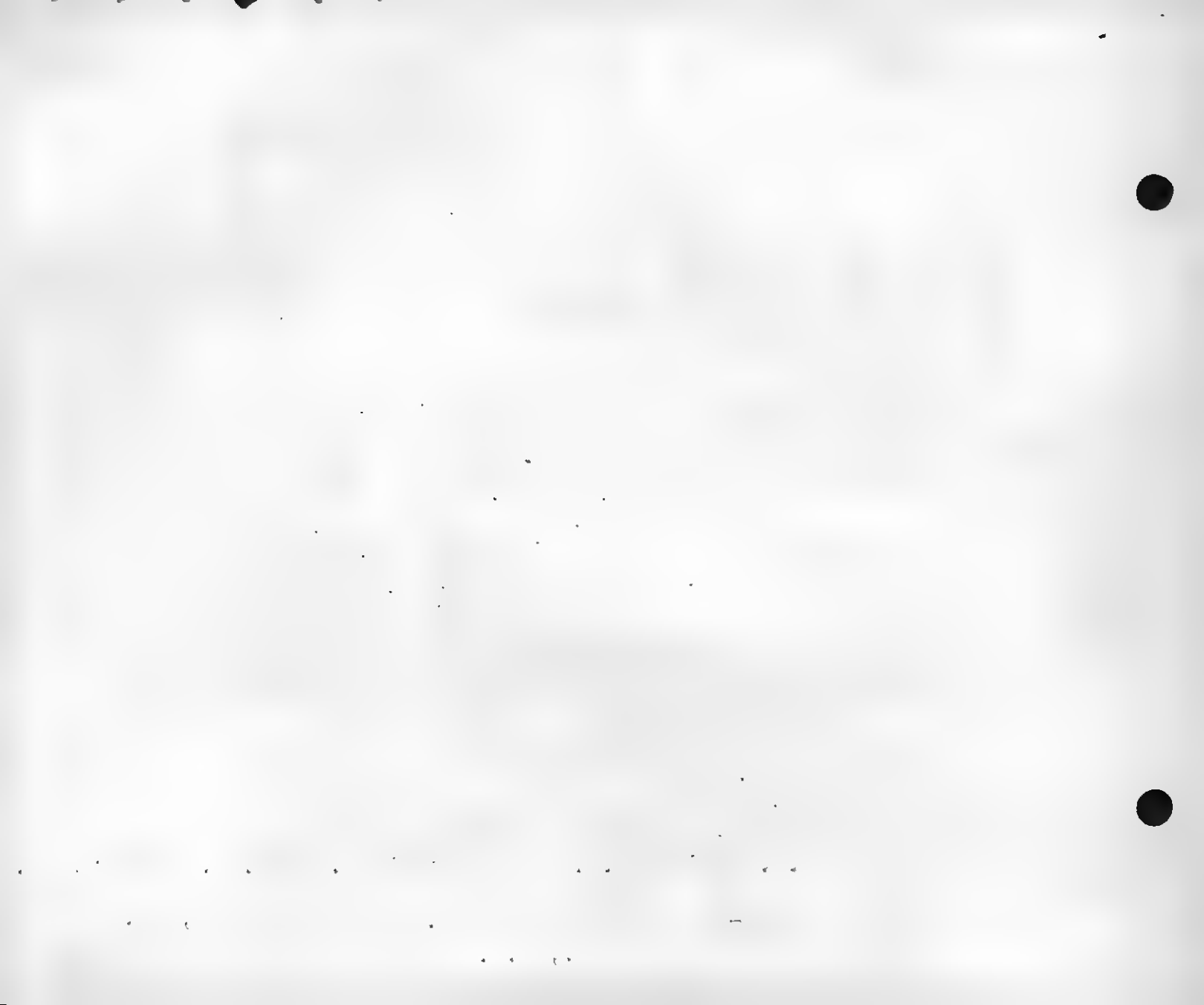
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Rockville</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			d. STREET ADDRESS <u>13419 Keating St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Mrs Mary Ella Wood</u>					DATE OF DEATH <u>June 13 1966</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 17, 1918</u>		9. AGE (in years last birthday) <u>49</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Joseph F Wood</u>					14. MOTHER'S MAIDEN NAME <u>Mary Coadrey</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Washington Sanitarium & Hospital</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>anoxia</u> DUE TO (b) <u>Malabsorption of food</u> DUE TO (c) <u>Carcinomatous of all abdominal organs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>5 years</u> <u>5 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1963</u> to <u>June 13, 1966</u> that (I) (we) last saw the deceased alive on <u>June 11 1966</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>W.W. Eastman</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 13, 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>W.W. EASTMAN M.D.</u>					22d. ADDRESS <u>831 UNIV. BLVD. S. SPRINGS, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-16-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEM.</u>		23d. LOCATION (City, town or county) (State) <u>ROCKVILLE, MD.</u>			
24. FUNERAL DIRECTOR <u>JOSEPH GAWLERS SONS</u>					ADDRESS <u>WASH., D.C.</u>		25a. REC'D BY REGISTRAR <u>JUN 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



FOR STATE
HEALTH DEPT.

008765

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08757

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>3617 Kirkwood Place</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>HERALD JOSEPH WORKMAN</u>		4 DATE OF DEATH Month <u>6</u> - Day <u>8</u> - Year <u>1966</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-29-48</u>
9 AGE (in years last birthday) <u>17</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> HOURS <u> </u> MIN. <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b KIND OF BUSINESS OR IND. STRY <u>None</u>	
11 BIRTHPLACE (State or foreign country) <u>Penn.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13 FATHER'S NAME <u>Joseph L. Workman</u>		14 MOTHER'S MAIDEN NAME <u>Rita Lynagh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Joseph L. Workman</u>		Address <u>3617 Kirkwood Pl. W. Hyattsville, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Accidental drowning while swimming</u> <u>7244</u> DUE TO (b) <u>in pool.</u> Conditions, if any, which gave rise to immediate cause (c). stating the underlying cause lost. (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased, drinking, unable to get back to shore after swimming.</u>		20c TIME OF INJURY Month, Day Year <u>3:45 pm 6/8 1966</u>	
20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Swimming pool</u>	
20f (City or town) <u>Silver Spring Montg. Md.</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.		22. DATE SIGNED <u>June 8, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP M.D.</u>		Address (Street, city, town, or county) <u> </u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-11-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or town) (County) (State) <u>Wheaton, Md.</u>
24. FUNERAL DIRECTOR <u>W. W. Chambers, Co.</u>		ADDRESS <u>5801 Cleveland Riverdale, Md.</u>	
25a REC'D BY REGISTRAR <u> </u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in paragraph 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08767

08758

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 50 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Maryland				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Campbell c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lynchburg d. STREET ADDRESS 201 Yeardley Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle Wayne Last Wright				4. DATE OF DEATH Month June Day 23 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 November 1908	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 5		IF UNDER 24 HRS. Days 23		Hours 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Managing Editor				10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Luther M. Wright			
14. MOTHER'S MAIDEN NAME Marie Parker				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 226-03-7061				17. INFORMANT The Medical Record, The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Retroperitoneal hemorrhage DUE TO (c) Primary aldosteronism PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Osteoporosis INTERVAL BETWEEN ONSET AND DEATH 2 days 10 years							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I (this hospital) attended the deceased from 4 May , 19 66 , to 23 June , 19 66 , that (we) last saw the deceased alive on 23 June , 19 66 , and that death occurred at 11:20 PM , from the causes and on the date stated above.							
22a. SIGNATURE Warren W. Davis M.D. 22b. DATE SIGNED 24 June 1966 22c. PHYSICIAN'S NAME (Type) Warren W. Davis, M.D. 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 27, 1966		23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY		23d. LOCATION (City, town or county) (State) LYNCHBURG, VIRGINIA	
24. FUNERAL DIRECTOR WHITTEN FUNERAL HOME, LYNCHBURG, VIRGINIA				25a. REC'D BY REGISTRAR JUN 28 1966 25b. REGISTRAR'S SIGNATURE Charles Judge			

CERTIFICATE OF DEATH

08759

08768

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Germantown, Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> <u>15 - 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>		d. STREET ADDRESS <u>Rt. # 2</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Kenneth Thomas Wright</u> First Middle Last		4. DATE OF DEATH <u>June 21 1966</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-4-95</u> <u>XXXXXX</u> AGE (In years last birthday) <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Military</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Ill.</u>
13. FATHER'S NAME <u>Thomas Wright</u>		14. MOTHER'S MAIDEN NAME <u>Emma Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-44-9926</u>	17. INFORMANT <u>Virginia Metz Wright, Age #2</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x</u> DUE TO <u>Intra-Cranial Hemorrhage</u> <u>right complete Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>H.C. U.D. - seven</u> lost. } (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 1966</u> to <u>6-21-66</u> , that (I) (we) last saw the deceased alive on <u>6-20-1966</u> , and that death occurred at <u>2:45 am</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Jack Schumacher</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>6-21-66</u>
22c. PHYSICIAN'S NAME (Type) <u>Jack Schumacher</u>		22d. ADDRESS <u>Gaithersburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-23-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Church</u> <u>Neelsville Presbyterian</u>	23d. LOCATION (City or Town) (County) (State) <u>Germantown, Md.</u>
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 24 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

082520

CONTINUED FROM PAGE 1

082520

1. The first part of the report is a summary of the work done during the last year. This includes a description of the methods used, the results obtained, and a discussion of the conclusions drawn. The second part of the report is a detailed account of the experiments conducted. This includes a description of the apparatus used, the procedures followed, and the results obtained. The third part of the report is a discussion of the results obtained and a comparison with the results of other experiments. This includes a discussion of the factors which may have influenced the results and a discussion of the implications of the results for the theory of the subject.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1M
67
1
99
6/25-10/23/66
Warner E. Pumphrey, Inc.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
08769										
08760										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN ID <u>D. O. A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>910 Venice Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>George</u> Last <u>ZACHARIA</u>			4. DATE OF DEATH Month <u>6</u> Day <u>25</u> Year <u>1966</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 22 1917</u>		9. AGE (In years last birthday) <u>49</u> yrs. IF UNOER 1 YEAR IF UNOER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>taxi cab driver</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Taxicab</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Johnstown, Pennsylvania</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Alex Abraham (Zacharia)</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Daley</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>yes</u>			16. SOCIAL SECURITY NO. <u>577-16-3950</u>		17. INFORMANT <u>Evelyn Zacharia</u> Address <u>910 Venice Drive Silver Spring, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct, posterior left vent.</u> 4201 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. b) <u>Occulsive coronary arterial atherosclerosis</u> c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 25, 1966</u> , to <u>June 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 25, 1966</u> , and that death occurred at <u>11:25</u> A.M., from the causes and on the date stated above.										
22a. SIGNATURE <u>Walter G. Goetz MD</u>					22b. DATE SIGNED <u>6/25/66</u>		22c. PHYSICIAN'S NAME (Type) <u>WALTER GOETZ MD</u>			
22d. ADDRESS <u>2390 GLENMONT CIR</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>June 29, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>					25a. REC'D BY REGISTRAR <u>JUL 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



Access to the information is restricted to the following:

Executive Director, National Health Service